A Supportive/Interpersonal Approach to Inpatient Group Psychotherapy  (updated February 2013)

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Abstract

This document describes a supportive interpersonal approach, in a mixed diagnosis group, focusing on empathic attunement. This group does not extend the length of stay of patients in the hospital, is highly valued by patients and staff and is a powerful tool for teaching Group Psychotherapy and Supportive/Expressive Psychotherapy principles to trainees.

Introduction

Interpersonal Group Psychotherapy was implemented on St Michaels Hospital in patient psychiatric unit in Toronto in April 2005. A predominately supportive interpersonal psychodynamic approach with a focus on the here-and-now is used. Attendance is optional and the population is heterogeneous, both in the range of psychopathology and in the capacity of psychological mindedness. According to Yalom, (1995), the main goals of Interpersonal Group Psychotherapy in an acute inpatient setting are to engage patients in the process of psychotherapy; demonstrating that talking helps; decreasing hospital based anxiety and encouraging altruism as well as problem spotting and decreasing isolation.

Rationale for having interpersonal group psychotherapy in an inpatient psychiatric ward setting

According to Yalom (1995), “The goals of the acute inpatient group are not identical to those of acute inpatient hospitalization. The goal of the group is not to resolve a psychotic depression, not to decrease psychotic panic, not to slow down a manic patient, not to diminish hallucinations or delusions. Groups can do none of these things. That’s the job of other aspects of the ward treatment program- primarily of the psychopharmacological regimen.” (Yalom, 1995, p. 459)

Goals of an interpersonal inpatient group

According to Yalom (1995), there are 6 achievable goals for Acute Inpatient Group Psychotherapy, including:
1) Engaging the patient in the therapeutic process
2) Demonstrating that talking helps
3) Problem Spotting
4) Decreasing Isolation
5) Being Helpful to others
6) Alleviating hospital based anxiety (Yalom, 1995, p. 459)

Description of the Supportive/Interpersonal Inpatient Group Psychotherapy at St Michael’s Hospital

1) Psychiatric In-patient unit at St. Michael’s Hospital, Toronto
2) General Group Program
3) Psychotherapy Group

1) ST.MICHAEL’S HOSPITAL
Is an acute care hospital located in the downtown Toronto.

THE INPATIENT MENTAL HEALTH UNIT
• 33 bed unit with 3 separate areas;
  – A general ward 23 beds,
  – Intermediate Care Unit 4 beds and
  – Acute Care Unit 6 beds.
• All of our units including the general ward are locked.
• 93% occupancy rate, average length of stay is 20 days.
• 67% of our patients are admitted on a Form 1.
• 11.5% of our patients are admitted more than 3 times a year

PATIENT POPULATION
• Wide diagnostic spectrum Axis I, II and III.
• Equal number of men and women
• The average age of men 53 and women 46
• 45% of patients have a co-morbid substance abuse diagnosis
• Wide spectrum of cultural, education and socioeconomic status.
• 48% of our clients have a history of violence.
2) THE GENERAL GROUP PROGRAM
   a) Description of the General Group Program
   b) Groups offered
   c) Beginning of the formation of therapeutic alliance

THE GROUP ROOM

   a) Description of the general group program
   The Group Therapy Program on our unit provides a forum for increased interactions with
   and among the patients. Our goal is to engage the maximum number and variety of
   patients to help them come out of isolation and tolerate being with others. The groups are
   geared to be inclusive. We try to engage our patients in a way that has mass appeal
   regarding ability and aptitude, and we allow for all levels of interpersonal functioning.

   b) Groups offered
   • Mindfulness Based Stress Reduction Group
   • Relaxation Response Group
   • Yoga / Tai Chi
   • Creative Expression
   • Coffee and Newspaper group
   • Nail Care group
   • Spirituality Group
   • Medication information group
   • Concurrent Disorders Group
### GROUP SCHEDULE 2008

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<th>Monday</th>
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<tbody>
<tr>
<td><strong>Early Morning</strong></td>
<td>8:30 COFFEE &amp; NEWSPAPERS</td>
<td>8:30 COFFEE &amp; NEWSPAPER</td>
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<td>Breakfast</td>
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<td><strong>Late Morning</strong></td>
<td>10:00 MINDFULNESS BASED STRESS REDUCTION</td>
<td>10:30 GROUP PSYCHOTHERAPY</td>
<td>10:30 GROUP PSYCHOTHERAPY</td>
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<td>Lunch</td>
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<tr>
<td><strong>Early Afternoon</strong></td>
<td>1:15 COMMUNITY MEETING Find out about the staff and services here for you! Coffee and Timbits will be served!</td>
<td>1:00 CREATIVE EXPRESSION</td>
<td>1:15 NAIL CARE &amp; MANICURE GROUP</td>
<td>1:00 CONCURRENT DISORDERS</td>
<td>1:30 YOGA 2:15 RELAXATION</td>
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<td>Lunch</td>
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<tr>
<td><strong>Late Afternoon</strong></td>
<td>3:00 SPIRITUALITY GROUP with our Chaplain</td>
<td>2:00 RELAXATION</td>
<td>3:15 MEDICATION INFORMATION with our Pharmacist</td>
<td>8:30 Friday/Saturday Popcorn &amp; Movies</td>
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c) **Beginning of therapeutic alliance**

- Repeated interaction with others
- Having positive experiences with others
- Familiarity with the group room
- Familiarity with Group leaders

It is through these repeated interactions with patients that a trusting relationship starts to develop. We believe that the attendance and quality of patient interaction in the psychotherapy groups is highly dependent on the larger group program that exists on the unit.

### 3) PSYCHOTHERAPY GROUP

1. Place and Time
2. Group Leaders
3. Inclusion and Exclusion Criteria
4. Patient Recruitment
5. Modifications of Technique
6. Strengths and Weaknesses of this approach
7. Outcomes

1) **PLACE AND TIME**

- Group room is in the inpatient unit
• As Frequently as feasible, the groups have been run from twice per week to five times per week over the years. At 10:30 am.
• 90 minutes when co-facilitated, 60 minutes when one facilitator

The location of the group in the in-patient unit ensures the safety of the group members who may be overly stimulated or upset by the group. On leaving the group the patients are in a secure space of the unit and one to one attention can be given to them by other members of their treating team. The unit is supportive of the group program and most often nurses and doctors schedule their one to one meeting with patients out side of the group times. This positive support needs to be earned and is a result of openness to discuss positive and negative aspects of the group with the unit staff and management, acknowledging group’s limitations and positive influences on the unit

2) GROUP LEADERS
   a) Nurse Group psychotherapist
   b) External Psychiatrist
   c) Residents in psychiatry, Nursing students

It is best if the Group can be co-facilitated to decrease the stress on the leader when the leadership is shared and debriefing at the end of the group helps reduce the stress of facilitation. Co-facilitation with students in nursing and medicine can also provide a unique opportunity to teach psychotherapy skills and allow the students to see their clients apart from their diagnosis, in a humanistic perspective.

a) Nurse group psychotherapist

As the unit’s Group Nurse, she enjoy a preferred status in that she is neither responsible for either medication administration or compliance nor enforcing any other aspect of the patient’s treatment plans. Patients who see her do so because they wish to. Their participation in groups may be solicited, encouraged or recommended by Group Nurse or another member of their care team, but it is never mandated or enforced. She has the opportunity to interact with potentially every patient on the unit on a daily basis. She attend daily unit rounds as well as weekly team rounds and have a good overview of the patient’s reasons for admission, diagnosis, treatment history and probable length of stay. This level of knowledge helps her ascertain who may be ready or suitable for group, and while all patients are provided with information and opportunity to engage in the group program, she may choose to solicit participation more actively according to clinical status. This constant exposure to and interaction with patients help to facilitate development of a trusting relationship.

b) External psychiatrist

An External Psychiatrist to the inpatient unit who does not engage with patients on an individual basis and is not responsible for their admission, discharge or daily care brings
in a nonjudgmental stance to the group. She does not engender oppositional behavior and
is in a position to view each person in the here and now of the group with minimal bias.
She is only aware of what group members have shared in the past and any significant
interpersonal or ward event that would be shared to her by the Group Nurse.

c) Students in medicine and nursing

The students are generally working on the inpatient ward and have direct contact with the
patients. If present for one or brief number of sessions they generally don’t feel
comfortable to actively take part in the group but benefit from observing how the leaders
facilitate the group. If present for more than a few sessions they are supported and
couraged to function as co-facilitators. The students observe and appreciate the
therapeutic factors of group in actions such as cohesion, altruism, catharsis, imparting of
knowledge and instillation of hope. They observe facilitators demonstrate empathy,
attunement and non-judgmental listening, which is applicable in both individual and
group modalities. They observe in the group and reflect in post group debriefings the
rational for therapist facilitation activities in the group. The students often comment that
they see their patients as humans rather than diagnosis when they see them interact in the
group sessions.

3) INCLUSION AND EXCLUSION CRITERIA
   • Inclusion: everyone is welcome
   • Exclusion: patients who are actively disruptive or offensive
Any and all patients are able to attend the group as often as they would like. This includes
patients who are psychotic those who are delusional and those who are manic. The only
exclusionary criterion is for actively violent or disruptive, behavior. Including patients
who are at lower levels of functioning also allows us to model tolerance and adaptive
interactions as well as providing some psycho-education regarding behaviors that may
otherwise be confusing and frightening to some patients. Over the last eight years only a
handful of patients needed to be “removed” from the group. The patients in question were
either disinhibited or non-redirectable or were decompensating psychologically due to the
increased stimulation of the group environment. The acuity of illness of the patients
requires a sensitivity to and knowledge of their readiness for group. Although
undoubtedly some patients are more ready to engage in the group, we rarely exclude
participation based on the severity of symptoms. We have patients in the group who are
floridly psychotic and interacting only with themselves

4) PATIENT RECRUITMENT
   • Voluntary attendance
   • Encouraged to attend by Group Nurse
   • Encouraged to attend by treating team
   • Encouraged to attend by other patients
   • Advertised on the unit
   • Announcement five minute before the group
Although the majority of patients are from the ward, we do routinely have patients form the Intermediate Care Unit and rarely from the Acute Care Unit in attendance. Sometimes this is because they themselves have expressed interest and sometimes it is because they have been strongly encouraged by their team to attend. On occasion patients are “tested” in the group to see how they will react to the milieu of the ward with varying results. The Group nurse approaches patients individually before each session; time permitting, in their rooms. Some Patients find that this personal invitation and encouragement gives them the needed impetus to attend the group. In addition, the group leaders make an announcement over the intercom 5 minutes before each session. That seems to be good enough amount of time for patients to make their way into the group room and settle. Any more time seems to negatively affect attendance, possibly due to memory or organizational challenges. One of the most stressful times for patients is waiting with others in the room before the facilitators arrive when there is unstructured time and possibly the pressure to socialize. Psychotherapy group is introduced and explained during the weekly Ward Community Meeting. The format of the group is explained and it is emphasized that participants will never be forced to talk and that they are free to come and go at will. It is stated that they introduce the topics that the group is not confrontational but supportive. Patients are also encouraged to attend by other staff including their nurses and psychiatrists. Not surprisingly the best advertisements for the group comes from the patients themselves. If they have found it helpful they often encourage others to attend the group.

5) MODIFICATION OF TECHNIQUE
   a) Serving of coffee and tea
   b) In and out policy
   c) Therapist approach and participation
   d) Introduction at the beginning of each group
   e) Helping patients underline the interpersonal issues
   f) Having an open forum discussing issues in more detail
   g) Being flexible in regards to the above structure
   h) Common themes

   a) Serving of coffee and tea
      • Implicitly suggests that the group is nurturing and warm
      • Lures patients in
      • Socialization
      • Sets a mutually contributory therapist member dynamic
      • Altruism
      • Occupies the patient while others are arriving

We offer tea and coffee, implicitly suggesting that the group is nurturing and warm. It also lures some people in who other wise would not be trying out the group. It serves as an opportunity for patients to practice socialization as well as altruism. Patients offer to pour each other cups in a most civilized manner and this simple act of caring can serve to increase patient’s comfort levels. Patients offer to pour tea for the facilitators as they
accept us serving them. This helps to remove the stereotypical therapist patient relationship, which is normally a top nurse/doctor - down patient dynamic. This social activity reduces the anxiety provoking experience of sitting around a table with strangers. And implicitly suggests that in the group the gifts of empathy and attunement like the coffee and tea are given from member to member.

b) In and out policy

• We encourage patients to be on time, though we welcome latecomers
• Patients can come and go as they please
• We ask the unit staff not to pull out patients during group time
• We encourage patients to stay as long as they can tolerate the group.
• Door to room slightly open at all times

Although we highly encourage patients to show up on time, we are flexible if they do not. Initially we had a 30-minute limit after which we would close the door, but this interrupted the flow of the session and did little to prevent disruptions, as often patients would continue knocking on the door until they were let in. There are potentially a number of other professionals involved in each patient’s care so this flexibility increases not only attendance but also collegial support. Although ultimately we are flexible about patients having to leave or arrive late due to previously scheduled appointments or procedures we have communicated to the rest of the staff that it is not acceptable to routinely come and pull patients from the group who could be seen at alternate times. This limit has been respected and communicates to the patients the importance of the group and promotes greater group cohesion. The door to the Group room is propped open so that patients may come and go during the session. This has been necessary modification to accommodate patients who are either too anxious to tolerate and uninterrupted session; those who are too restless or apathetic to remain seated for such an extended period of time as well as patients who simply need either a cigarette or a bathroom break. Patients are also free to leave without explanation if they are alternately bored or triggered by the content being discussed that day. We have found this very helpful in order to allow patients the opportunity to control the material they are exposed to. If they are triggered by someone else’s disclosure or affect they can leave the group as an act of self-protection. Sometimes they don’t return, but often they do, after self-soothing or asking for a prn medication. We do not require that patients explain why they are leaving, and this is explicitly communicated in the introduction at the beginning of each group. Making this part of the group structure not only normalizes the behavior of “leaving when you need to” but also increases the likelihood that reluctant patients will come and try out the group in the first place.

c) Therapist approach and participation

• Therapists are very active
• No one is forced to speak
• All topics and all expressions of affect are allowed except aggression or offensive behavior towards other members
• All topics are framed in the interpersonal context
• We actively redirect
• At times we are Transparent

We are very actively participating in the process. We do this to decrease anxiety of the clients in the room and to bring structure to the group and model appropriate behavior for the Patients. We seldom let the group go quiet for more than a few seconds. We reassure the patients that they will never be forced to speak. We communicate through out the group that what the members talk about will come from them and not us; the idea that they only speak about what they are comfortable talking about and the fact that they do not have to speak at all. This enables those who otherwise lack the social skills or ability to articulate themselves due to the acute nature of their illness to attend and benefit from both vicarious learning and exposure to therapeutic milieu. We do not exclude any topic or expression of affect, with the exception of aggression or discriminatory behavior towards group members. Although we do make an attempt to provide a safe containing atmosphere, it is not at the sacrifice of spontaneity or expression. If there are topics or affects that again are unacceptable or intolerable, patients are of course free to leave and return to the group as they wish. Our openness to meet patients where they are allows us to work with a very heterogeneous group. We attempt to reformulate whatever topic comes up in the interpersonal context and in this way can find commonality among the many different expressions such as depressive rumination about not being good enough by one patient and psychotic paranoid fear of being attacked by another. In this situation we may remark that both patients are feeling hurt by others not valuing them and they react differently to protect themselves. One lashes out and the other puts him down before others do it to him. We allow the participation of clients at all levels of functioning and regardless of their diagnosis. We actively redirect disinhibited patients. By using our first names we also hope to offer an alternative to the patient-doctor relationships that exist on the unit. Implicitly again enforcing the idea that we are not there to judge in a clinical way but more so open to hear from them as a person and not just as a patient. We are also open to share from own experiences in a judicious way that would enhance the working of the group. This helps to model emotional expression, normalize stereotypes and to acknowledge that we are all human.
d) Introduction at the beginning of each group
• Describe the group structure
• Emphasize the interpersonal focus
• Emphasize flexibility and the voluntary nature of the group
Inpatient groups are constantly changing in membership and each group needs to be seen as a group to itself. Each group begins with an introduction to both the structure and process of the group. The timeframe is stipulated, group norms are reinforced, including the option to remain silent or leave at any time.

e) Helping patients underline the interpersonal issues
The group members are encouraged to start by raising an interpersonal issue. During their interaction in the group we try to draw similarity between members issues and underline the interpersonal challenges while normalizing them as a common issue shared by others. At times of silence we bring the group attention to the process at play wondering how they are affected by the process and yet again underline the interpersonal nature of the dynamic at play in this instance the silence. If the membership of the group is not benefiting from the approach we will move on to psycho-education. There are always some topics that would interest the group. If this also fails to engage the group, we acknowledge that there is not much to talk about that day, and contrary to what other group therapists in regular groups would do, we end the group early.

f) Having an open forum discussing issues in more detail
• Underline patient dynamic
• Look for commonalities- universality
• Patient driven: imparting information, empathy and altruism
• Learn from the positive here and now interaction
• Limit negative interactions by active intervention
• Don’t explore negative interpersonal interactions when they happen
• Model constructive behaviors and approaches
• Encourage reflection
• Model tolerance
• Allow constructive catharsis
• Always acknowledge the pain and suffering
• Always bring in the positive perspective

If the beginning phase of the group runs according to plan and members do raise interpersonal issues, these are summarized briefly with the aim of underlining the issues. Every time a new member enters we try to repeat the concerns brought up earlier both with the aim of giving importance to what was brought up, underlining the issue another time and help to refocus the group on the task of looking at interpersonal issues. We always point out that we will discuss the issues in more detail in the main body of the session. We continuously look for commonalities between the issues brought up. This linking works to increase group cohesion and emphasize the universality of issues patient struggle with. We actively try to help patients comment on each other’s issues and
express how issues raised affect them. Allowing the opportunity for interacting in an intimate way in the safety of the group members learn that they can be a support to each other while on the unit. This brings them out of their isolation and re orients them to the pleasure of relating to another person. We work in the here and now to the extent of showing positive interactions and how they affect members. We actively try to minimize conflicts or negative interactions and when they do happen we do not explore them in the here and now and find supportive ways to end the conflict. To work productively with negative interactions among group members one needs a cohesive psychologically motivated group. That kind of group seldom forms in the context of our in-patient groups. We actively try to model constructive ways of relating with others, by implicitly modeling tolerance, empathic listening, and setting of proper boundaries. We encourage productive catharsis and are always limiting too much sharing by patients. We always acknowledge what has been brought on by the group members regardless of their negativity, paranoia, delusional nature or intensity of hopelessness connected to it. However we always try later on to bring in the positive aspect of the situation that was left unsaid.

**g) We are flexible in regards to the above structure!**

We remind ourselves that the foremost goal of the group is to give the patients a positive communal experience and bring them out of isolation. We are flexible and will change our structure and approach so to attempt to reach the above goal.

**h) Common themes**

- Stigma of mental illness
- Loneliness and isolation
- How to engage others
- Low self esteem
- Practical concerns regarding being on the unit
- Practical concerns about treatment options

There are a number of concerns that are routinely expressed by our patients. Patients are often concerned about the stigma of mental illness and what if anything is told to significant others in the patient’s life regarding hospitalization. Members often speak of loneliness and isolation, negative self-talk and low self-esteem as a consequence of mental illness and as an insufficient coping strategy. We discuss how to engage the support of others whether family, friends or community supports.

Often patients are struggling with how to Interact with other staff; and negotiating treatment options with their medical team and dispute resolution with others on the unit. Practical concerns regarding passes, involuntary admission, review board hearings that they encounter while a patient on the unit are often discussed.

The facilitators are asked often to remark on a wide range of topics such as medications or ECT, specific symptoms of illness, various forms of therapy such as outpatient groups,
Mindfulness Based Stress Reduction, Meditation, individual psychotherapy and psychoanalysis

6) STRENGTHS AND WEAKNESSES OF OUR APPROACH

STRENGTHS
a) Benefit to patients
b) Benefit to unit as a whole
c) Educational benefit to the co-facilitators

a) BENEFIT TO PATIENTS
• Reducing of isolation (THE SAME AS OTHER GROUPS)
• Social skills experience (THE SAME AS OTHER GROUPS)
• Experience the benefit of talk therapy
• Catharsis
• Universality
• Information sharing among patient
• Altruism
• Highlighting interpersonal patterns
• Learning from others experiences
• Helping to resolving impasses with their treating team by discussing it in the group.

b) BENEFIT TO UNIT AS A WHOLE
• Unit calmer
• Additional information for the treating team

The empathic attunement and the facilitation of the expression of affect as well as a forum for voicing complaints have made the unit a much calmer place. We think this is due to patients getting to know each other in a therapeutic milieu that provides modeling of tolerance of individual symptoms as well as differences. Behaviors that may have frightened or antagonized others may be better understood through the provision of psycho-education as well as the modeling of more adaptive coping strategies. Patients help one another; befriend one another and come to understand each other and this has improved the general atmosphere on the unit as appropriate interactions are normalized. The group simply helps socialize the unit!

There is a richer source of information about each patient that is generated from his or her participation in the group. This information is communicated to the various care teams on a weekly basis in addition to the daily notes that are taken on each patient’s participation. It allows us another opportunity to know patients, not as isolated subjects but as interactive and dynamic participants in a therapeutic social milieu. Issues that are not specifically addressed in a more structured assessment are allowed to percolate and reveal themselves over repeated daily contacts in the group. The problem spotting that occurs in the group is invaluable in directing further care or assessment needs.
c) EDUCATIONAL BENEFIT TO THE CO-FACILITATORS

• Not doing groups in isolation
• Learning from each other

Interdisciplinary collaboration provides an unparalleled learning experience. The post group debriefing sessions allows the facilitators to learn from each other and as they communicate their own reaction and thoughts about the group to each other we generally come up with new insights. The groups are an exceptional opportunity to teach students basic psychotherapy skills. These skills are thought in the here and now of the clinical situation which students would not be able to attend in regular psychotherapy modalities due to confidentiality and long-term structure of the session. In the inpatient groups as patients are free to come and go in the group so are the student therapists. As each group is a finite therapeutic experience, students who may be doing as brief as a one day rotation in the unit can have a psychotherapy learning experience.

This group structure also lends itself to the more classic way that residents are trained in Group Psychotherapy. Residents can either co-facilitate with another resident or a staff psychiatrist or Group nurse on steady basis or have a different co-facilitation experience from group to group. This will allow the resident to reflect on effects of co-facilitation on the group dynamics as they compare and contrast their experiences. Also the structure of this group allows for the residents to have the flexibility of having missing groups due to other program requirements without negatively affecting the group members and process group.

Due to the structure of these groups there have been a wide variety of others who have attended groups as part of their learning experience, including Nursing Students, newly hired nurses, Occupational and Recreational Therapists.

WEAKNESSES

a) For patients
b) For unit as a whole
c) For co-facilitators

a) WEAKNESSES FOR PATIENTS

• Psychologically minded patients may not be able to work on their issues
• Less psychological patients may be too overwhelmed by psychodynamic issues brought up
• Intensity of topics not suitable to all members
• The lack of structure may be too confusing and irritating for patients

Although we do attempt to be inclusive and address as many issues as possible during each session, there are times when the diversity of the group makes it difficult to discuss concerns in a way most suitable to each group member. On occasion patients who wish to engage in a more reflective stance may find themselves in a group where strong affects or acuity of illness make it challenging to engage in an in depth discussion. Others may not be able to tolerate simply listening without engaging in the discussion and may interrupt
those who wish to articulate their concerns at length. There have also been times when patients have commented in an insensitive or inappropriate way to issues raised by others. The issues that some patients raise in the group may be too complex and inaccessible to other patients. Occasionally patients come to group and state their intent to “listen only.” At times if there are no topics on the table that they identify with, patients may sometimes choose to leave the group. Topics such as abuse, suicide and sexuality sometimes overwhelm or alienate patients who may then choose to leave the group. Some patients have objected to way others are allowed to come and go during the session. Others have shown sensitivity to people leaving, particularly if it follows a self-disclosure they have made. These issues are then processed in a here and now orientation in the group as they occur.

b) WEAKNESSES FOR THE UNIT AS A WHOLE
Because neither facilitator is responsible for treatment protocol such as involuntary status or medication compliance, we enjoy somewhat of a preferred status. Patients may split between us and other members of their care team who often have active goals or agendas for the patient or who are not so readily available. Groups do take a significant amount of time out of the patient’s day and reduces their availability to other staff.

c) WEAKNESSES FOR CO-FACILITATORS
- Any challenges that come up in co-facilitated groups in general
- Different style of therapy used by therapist may at times cause issues.
- Splitting that may happen in any co-facilitation augmented by the patient issues.
Clinical Data

Patient Attendance Data

- From January 9 to April 6, 2012, 157 consecutive discharges were evaluated regarding use of interpersonal groups.
- Min group 3, Max group 13
- Mean 7
- 65% of the 65 female patients and 61% of 91 male patients at least at one point during their stay attended the group.

**Group Attendance by Diagnosis in 157 Patients over 3 months**

- **Group not an option**, for patients who were never on the General ward during their admission
- **Chose no Group**, for patients who were on the General ward at some point and did not chose to attend groups
- **Little group engagement**, for patients who came to the group briefly and less than once per week.
- **Good group engagement**, for patients who came to the group for the majority of the session and attended more than once per week
Correlation between Length of Stay (LOS) at St Michael's Hospital and comparable Toronto Hospitals who don’t have an inpatient psychotherapy program.

Data was obtained from Canadian Institute for Health Information (CIHI) for the period of 2004 to 2010. To compare LOS before and after introduction of interpersonal group psychotherapy program in St. Michael's hospital on May 2006.

For psychiatric inpatient wards for Toronto general hospitals (St. Michael's Hospital, Toronto East General Hospital, Toronto General Hospital, St. Joseph's Health Centre, North York General Hospital, Sunnybrook Hospital, Mount Sinai Hospital) for confidentiality purposes only SMH data is identified by name.

Data was obtained regarding age, gender, diagnosis, fiscal year quarter and LOS. No significant difference was found in LOS for the two years before and the four years after the institution of the Interpersonal Group program.

SMH was compared to Hospitals C and E, which according to CIHI data are comparable size units with comparable patient diagnosis, gender and age.

Except for Mount Sinai Hospital (most likely Hospital F in the graph below), SMH is the only hospital in the Toronto that has a psychotherapy group program. The Program started in May 2006. Therefore comparing the SMH LOS data to comparable hospitals can help explore if the institution of such a program has increased the LOS at SMH. Comparing the LOS data before and after May 2006 in the following graphs for Diagnosis, Gender and Age shows that the institution of the group program at SMH has not significantly increased LOS in any of those categories.

Blue Arrow shows when the psychotherapy group program started.

![LOS at SMH and two similar Toronto Hospitals](image)
See addendum (1) for more graphs showing LOS data according to diagnosis gender and age.

Comparing LOS to Group Engagement

Data regarding the 157 patients followed from January to April 2012. Comparing LOS to Group Engagement. Overall no significant difference was seen in LOS between patients who used the groups and people who chose not to use the groups.

- **Not engaged with groups**, for patients who did not come to the group to came to the group briefly and less than once per week.
- **Engaged with groups**, for patients who came to the group for the majority of the session and attended more than once per week
PATIENT GROUP PSYCHOTHERAPY FEEDBACK QUESTIONNAIRES

Feedback questionnaires were randomly distributed to patients after participation was optional and anonymous.

Total of 27 Sessions

| Total Number of patients in these sessions: | 173 |
| Total # of Responses: | 103 | % 60 |
| # Of patients who agreed the session had been helpful: | 100 | 97 % |
| # Of patients who agreed the session had not been helpful: | 0 | 0 % |
| # Of patients who circled both answers: | 3 | 2.9 % |

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<th>Facilitator(s)</th>
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</thead>
</table>

Please circle true or false.

I found this group helpful | False | True |

Any other comments you would like to make?
________________________________________________________________________
________________________________________________________________________
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________________________________________________________________________
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All answers will be kept confidential and anonymous. You do not need to put your name on this.

Please give this questionnaire and the pen provided back to your nurse or slip it under the Activity Group Room Door.

Your opinion matters! Thank you.

Please see addendum 2) for detailed narrative feedback comments from patients and Staff at the psychiatric unit at St Michael’s Hospital.
ADDENDUM

(1) Graphs on Length of Stay (LOS) comparisons between different hospitals and LOS data according to diagnosis gender and age.

Blue Arrow shows when the psychotherapy group program started
Blue Arrow shows when the psychotherapy group program started
Blue Arrow shows when the psychotherapy group program started
(2) Feed back from patients and staff
PATIENT’S NARRATIVE FEEDBACK COMMENTS

“I believe that the group was very helpful and there was a warm and inviting session with all of the pleasing art that was on the walls. There was no pressure to talk but when the notion came on, people would listen. All wonderful comments and hey there was tea to boot. Kas and Barbara made it easy to open up.”

“When I first heard about Group Psychotherapy I was skeptical. It became a critical part of my progress and improvement. Fellow patients were helpful. Barbara is compassionate and skilled and works hard. Thank you!”

“In spite of the focus being Interpersonal issues, it is difficult to predict what the group will present as topics of concern. i.e. Masturbation mixed with religion and canoeing makes for quite the gong show and it can be unexpectedly triggering. I propose restrictions on certain word selections; less graphic but still the subject can be understood.”

“I think that this group is very helpful to the patients within this unit. Communication is always the key for people to share.”

“I found that the group has an understanding and positive atmosphere. Larger groups cause me much anxiety but this one was small and it was easier to speak about myself.”

“I find it hard to take other people’s problems at this time, but I am keeping an open mind to different things. Barbara did a wonderful job mediating and facilitating the discussion. We each have our own problems and sometimes they do not relate to what we each have difficulty with, but I found listening was very interesting. I would like to keep coming and hopefully I will overcome my own inhibitions to being in and contributing to the group.”

“I found some parts very helpful. Not sure what to do about people who dominate the discussion.”

“I wish everybody would interact in the group meetings. It would be helpful to them. I found it helpful and stress reducing. Thank you.”

“Although my issue feels that it has not eased, I know I have made the first step by voicing how I am feeling.”

“Very constructive in venting internal concerns within the hospital unit.”

“Some of the comments made were very helpful. I didn’t realize other people feel harshness toward themselves.”
“Everyone was sharing their feelings and a bond could be felt between the participant which made this session really interesting and enjoyable.”
“Best therapist I’ve witnessed. Ever.”

**STAFF FEEDBACK**

“As for the group, I think it is tremendously helpful. Large numbers of patients report spontaneously that it helps them to consider their illnesses and lives from a humane perspective those complements, but is distinct from, the medical viewpoint. They really appreciate being able to reflect in the company of peers. It often engenders an enhanced sense of support on the ward, and this can be a catalyst for recovery among patients who have been feeling isolated or neglected or dismissed. I also find it very helpful to hear from you how patients have been tolerating group: it often serves as a benchmark for when a patient is ready to discharge, move to the ward, or go on passes off the ward. Patients' behavior in a large social setting is very different from that in a one-on-one session with a nurse or physician, so it's so helpful to get the group therapy feedback.”

Dr. D. Robertson, MD, FRCP (C), Staff Psychiatrist, St. Michael’s Hospital

“I think it's important that patients have the opportunity to share with and support each other with staff who are more 'neutral' for lack of more descriptive words. It is an important way of emphasizing treatment strategies. This is dependent on communication with group therapist (you) and nursing staff such as myself. Unfortunately, this is not always possible due to the usual hectic pace on the unit. I found that when I did make that extra effort to speak with you about a patient, the benefits of other therapeutic interventions were increased. The notes are very helpful but again, speaking for myself, I do not always get around to reading them. I think the psychotherapy group is very important and necessary. At times, however, it feels like an activity that is happening 'out there' somewhere and is not tied into the unit. I am not sure why that is because you take part in all the rounds and are visible, vocal etc.” Yvonne, Staff RN, St. Michael’s Hospital

“I only have positive feedback about the Group Psychotherapy session. It provides a valuable experience for patients who are hospitalized, and I consider it a part of the treatment that patients receive when they are on our ward. The sessions allow patients to share their experiences, test out how they are seen by others, receive support, but also engage in supporting others. Sometimes the group offers something as simple (but psychologically complex) as activation for our patients and social contact that they were missing in their lives. There's an element of the group that provides a "shared experience" and "I'm not alone in my suffering" type of understanding. I believe the group has an additional component, a more therapeutically active one that helps patients challenge misconceptions they have about themselves and others that might have led to emotional difficulties.” Dr. K. Shin, Staff Psychiatrist, St. Michael’s Hospital

The group has been a very important addition to what we offer for our inpatients, and is highly valued. The quality of therapy has been excellent. Patients often reflect in their individual sessions with the medical team on what they talked about in the group, and it is clear that it helps advance their treatment. Many patients comment on how helpful it is
to hear that others struggle with similar problems. This appears to be particularly valuable for our socially isolated patients. The quantity and continuity are also important. Patients often complain of boredom on the unit, and they look forward to the group as a place where they can work on their issues each day. On the busy unit where psychiatrists may have limited time to spend with patients, the group may be the primary psychotherapeutic intervention for some patient. The group also enriches the assessment of the patient by providing feedback about patient function in the group setting. This feedback is provided through chart notes and verbally from the Group Nurse and at weekly team rounds. It also helps assess when patients can be transferred from more to less acute beds. The group helps the patients indirectly in developing their social skills. It also provides a valuable learning opportunity for staff of many disciplines, i.e. Residents”

Dr. K. Balderson, Staff Psychiatrist and Medical Director of the Inpatient Mental Health Unit, St. Michael’s Hospital

“Regarding the group psychotherapy program that you and Kas have developed at SMH, having attempted to do the same thing approximately 8 years ago at Toronto General Hospital, albeit less successfully, I know how challenging and complicated it can be to set up a program that meets the needs of such diverse and often acutely ill patients. I have been extraordinarily impressed by the work you've been doing and have consistently gotten feedback from my patients about the value of the groups in contributing to their improvement during their time on the 17th floor. As you know, it has been quite commonplace for patients to want to do "one last group" before being discharged and many patients have asked me if something like your groups are available after discharge. The attendance levels of your groups are better than what we achieved at TGH and I think the role of the group program is more integral to patient care than what I saw at my previous hospital. One of the things that has been lost in the modern inpatient unit, with it's emphasis on efficiency and reducing hospital length of stays, is the understanding that the" milieu" of the unit is one of the most powerful therapeutic forces contributing to patient change. The milieu creates an atmosphere of compassion and emotional responsiveness that reduces a patient's sense of aloneness and provides validation for their suffering. While we try and provide this through therapeutic encounters on the ward, I think the group program that you have designed is the most significant factor in creating this atmosphere and establishes a climate of tolerance, safety and universality. It helps patients to feel safe and less frightened about an inpatient stay and generates at times an increased concern for their fellow patients who they would not necessarily meet if it were not for the groups.” Harold Spivak, MD, FRCP (C), Staff Psychiatrist, St. Michael’s Hospital

REFERENCES